

**UNIVERSITY OF MEDICAL SCIENCES (UNIMED),
LAJE ROAD, ONDO CITY, ONDO STATE.**



**OFFICE OF THE REGISTRAR
PATERNITY LEAVE FORM**

Staff Number

Full Name

Designation

Date of Appointment

Department/Faculty

Contact Leave Address

GSM Number Number of Leave Days/Weeks

Date of Previous Leave

Date proceeding on Paternity Leave

Date Leave Ends

Date of Resumption for Duty

Staff Signature Date

Person responsible for duties during absence {If applicable}

Please attach proof of child's paternity and proof of child's delivery

Comments by the Head of Department/Unit

Name/Signature of the HOD/Unit Date

Comments by the Human Resources Officer

Signature Date

Comment(s) by the Registrar.....

Signature..... Date.....